

MENTAL ILLNESS: SOME ECONOMIC AND LEGISLATIVE CONSIDERATIONS

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by

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As a newspaper reporter who toured scores of state mental hospitals in the period 1945 - 1950, I can state categorically that care of the mentally ill then was at a frightfully low ebb.

The "philosophy" underlying legislative provisions for the mentally ill was a very simple one. They were a hopeless segment of our society, untreatable and incurable, and therefore certainly not a medical problem. They were accordingly given minimum custody in large institutions whose superintendents were frequently more concerned with the animals on the institution farm than with the patients on the crowded wards.

Apart from humanitarian considerations, the operation of most of these institutions struck those of us who observed them closely as extraordinarily uneconomic. Because staff salaries were frightfully low, the turn-over of personnel was exceedingly high. Although the daily maintenance cost per patient was minimal, the lengthy hospital stay of the average patient - eight years - meant that the total cost per patient involved a tax outlay running into thousands of dollars.

Because intensive treatment of the mentally ill was a rarity, it was inevitable that the flood of patients would create an incessant demand for more and more institutions.

For example, in the decade from 1945 through 1955, the resident population of these human warehouses was increasing at the rate of 12,000 patients a year. This massive addition of more than 100,000 patients in a decade necessitated the appropriation of hundreds of millions of dollars of state revenue for new buildings. In many states, because of the tight revenue picture, this additional construction had to be financed through the expensive fiscal mechanism of bond issues.

When some of us argued that the whole system was bankrupt and in need of drastic overhaul, we were told that since the establishment of the first public mental institution in Virginia in 1773, this had been the way things were done.

Since society rejected the mentally ill, the best sanctuary for them was a haven in the wilderness.

In a few states, there were sporadic revolts against the old custodial morass. Spurred on by newspaper exposes, governors and legislators allocated monies to clean up the snake pits. But most of these reforms were of a surface nature - they rectified some of the more flagrant inhumanities, but did not touch the rotting foundations at the core of the whole system. They were crisis-oriented reforms, buckets of water designed to put out sporadic fires of public indignation.

The first attempts at a widening attack upon the custodial philosophy came through the aegis of the National Governors' Conference.

In 1949, the Conference authorized a study of the status of treatment of mental patients in all state institutions; the 1951 Conference authorized a survey of possible alternatives to the weary, tradition-bound system which had outlived its usefulness.

These studies led to a National Governors' Conference on Mental Health in 1954. Proclaiming that traditional custodial care of the mentally ill had reached a dead-end, that historic Conference advocated a new emphasis upon active treatment of mental illness through psychiatric direction of state mental hospital systems and through increased appropriations for psychiatric research and training.

A few of the states moved in the direction of carrying out the major recommendations of the Conference, but most of them lacked either the will or the financial resources to implement them.

The advent of the tranquilizing drugs provided a new therapeutic weapon to stir up the stagnation of state mental institutions.

In the five-year period since the introduction of the drugs, there has been a remarkable drop of 23,000 patients resident in our state hospitals. This appreciable reduction, as contrasted to the seemingly inevitable rise in resident mental patients before 1955, has resulted in a saving in construction of new beds which would have cost in excess of \$1½ billion.

Despite these advances, the burden upon the states for care of the mentally ill continues to be a very heavy one.

In 1960, according to the National Institute of Mental Health, the fifty states spent \$927 million for maintenance and treatment of patients in state mental hospitals. In addition, the states spent more than \$250,000 for the operation of institutions for the mentally retarded. Furthermore, it is important to note that these figures do not include mental hospital construction costs running close to \$100 million a year.

In looking at the total sums expended by the several states for care of the mentally ill, several factors should be emphasized.

First of all, there has been an encouraging increase in state and local support of community mental health services designed to replace, in some degree, the monolithic emphasis upon institutional care. As against less than \$10 million allocated for these services in 1948, it is estimated that about \$80 million is now appropriated by state and local governments for a variety of these community psychiatric services.

Secondly, and in response to those who point to greatly increasing investments by state governments for care of the mentally ill, it should be carefully noted that the portion of the state tax dollar going for these purposes has not increased - it has actually shown a small decrease since 1952. Education, which obtains 31% of the state tax dollar, and highways, which claim 28%, have shown the sharpest proportionate increase over the past decade, with care of the mentally ill being allocated only a little more than six percent of the state tax dollar.

Mental illness also accounts for only about one percent of accumulated state debt, as against more than 50% accounted for by highway construction.

However, these fragmentary figures tell only a part of the story - they are restricted to state activities in the field, and do not give us a broad look at the total impact of mental illness upon this democracy.

In 1958, with the publication of the "Economics of Mental Illness", we as a nation obtained our first clear picture of the staggering cost of mental illness.

Estimating the total direct and indirect cost of mental illness as in excess of \$3 billion a year, the 1958 study cautioned that this estimate did not include capital construction and represented only a minimal approximation of the cost of private psychiatric care.

Furthermore, it emphasized the tremendous loss to society involved in the more than 200,000 admissions to our state mental hospitals each year. Pointing out that the greatest wage and productivity loss occurred in those patients aged 25 to 34, it underlined the stark finding that potential earnings of all first admissions in any one year to state mental hospitals alone exceed \$2 billion.

This is one dimension of the real cost of mental illness to our society.

These rough estimates overlook a multitude of additional costs to our economy through disturbed and ineffective behavior.

For example, the industrial mental health division of the Menninger Foundation has reported that emotional ills among industrial employees cost this nation billions of dollars in productivity losses each year. Absenteeism, most frequently due to psychological causes, costs nine billion dollars a year. Alcoholism represents an annual loss to industry in excess of a billion dollars.

What of the costs of juvenile delinquency, of drug addiction, of broken homes due to emotional incompatibility of marriage partners?

The important point here is that we bear these costs whether we know it or not. In other words, we bear the heavy, below-the-iceberg cost of mental illness even if we insist upon continuing to focus upon the small part of the iceberg which is visible.

For the first time in the history of the care of the mentally ill in this country, we now have a comprehensive report which puts these problems into proper focus.

It takes a sweeping look at every governmental and non-governmental resource available for the handling of mental illness, and it finds these resources pitifully inadequate to the size of the problem.

In the very simple statement that only 50% of the patients in state mental hospitals are being treated, and that only 20% of these hospitals have embraced new methods to make them active treatment rather than custodial institutions, there is contained the core of the challenge facing all of us.

In the forthright admission by the Commission that the large state mental hospitals of today are therapeutically bankrupt is embedded the spark of the revolutionary reforms which must gradually replace them as the major locus of care for the mentally ill.

Of particular interest to this gathering is the Commission's finding that we have two rigidly distinctive classes of public care for the mentally ill - one for our veterans and one for the rest of the population.

The mental hospitals of the Veterans Administration operate at a per diem in excess of \$12.00 per patient. They have a ratio of one staff employee to every patient and their rehabilitation programs meet the highest standards.

By way of contrast, state mental hospitals operate at a level of a little better than \$4.00 a day per patient, and they have but one employee for every three patients.

In order to lift state mental institutions and related services to acceptable standards, the Joint Commission recommends a tripling of national expenditures for mental health services by 1970, with the federal, state and local governments sharing in these expenditures.

Pointing out that it is impossible for state government to finance so vast a program, the Joint Commission report criticizes the heavy past reliance upon state expenditures in these frank words:

"It was a historic mistake to make the state alone virtually responsible for public care of its mentally ill residents, relieving the local communities of all future concern and until recent times sparing the federal government anything but peripheral involvement in the problem. Their single source of financial support guarantees the isolation of state hospitals and the dumping ground effect we have stressed."

The proposal for a federal matching grant is anything but revolutionary.

In 1854, the Congress passed legislation granting 12 million acres of federal land for the purpose of aiding in the construction and maintenance of state mental institutions. The bill was vetoed by President Franklin Pierce, and the problem was then thrust in even greater degree upon the states.

The Joint Commission proposal for matching grants does not envisage a crash program which would be very wasteful in pouring monies into many areas with insufficient psychiatric manpower and facilities to spend these funds wisely. Time and time again, the report emphasizes that the federal share of the matching grant should be arrived at in a series of graduated, carefully planned steps over a period of years, with the matching formula adjusted each year to the amount of state funds spent during the previous year.

It is also important to note that the states are required to qualify for participation in this matching grant and must meet certain minimum standards

to be formulated by an expert advisory committee appointed by the National Institute of Mental Health. While a certain proportion of the grant would go to bolstering and improving existing treatment services, a major part of the grant would be of the incentive type, serving as a stimulus to the states to create new psychiatric services.

The Joint Commission is acutely aware of the tight revenue situation at the state level and therefore it does not make unrealistic fiscal demands upon the states. It offers an incentive to states and localities which adopt new treatment services, but it also aids these jurisdictions of government in bolstering their existing treatment services.

It would not relieve any segment of the government of its financial responsibility.

First of all, in noting that care of the mentally ill is the one large health problem without any sizeable federal grant, it substantiates the need for federal involvement in the nation's number one health problem.

The Joint Commission proposal asks state governments to do much more than they have been doing.

It particularly charges the states with responsibility for the development of research and training programs designed to convert state hospitals into active treatment centers. It also calls upon the states to develop experimental facilities - small intensive treatment hospitals, day and night hospitals, half-way houses, etc. - designed to eventually replace mental institutions of 1,000 beds or more.

It requires local governments, which in many states have used the public mental hospital as dumping grounds for their unwanted citizens, to provide

expanded community psychiatric services before receiving any matching financial assistance. The report notes:

"The program would not only relieve the states of the sole responsibility for public care of the mentally ill, but would also meet the great objection to federal aid to the states which is that it usurps or weakens local responsibility. Our proposal would encourage local responsibility of a degree that has not existed since the state hospital system was founded."

We of the Joint Commission have been delighted and frankly, somewhat amazed, at the favorable reception our proposal has received within both the executive and legislative branches of the federal government. We think this reception is all the more amazing because it involves a fairly heavy additional cost to the federal government.

In a speech at St. Elizabeths hospital on May 3rd of this year, Secretary of Health, Education and Welfare Abraham A. Ribicoff endorsed the principle of additional federal financial responsibility in these very forthright words:

The facts are in. The Joint Commission on Mental Illness and Health, which was authorized by the Congress, took more than 5 years, spent some \$1.5 million, to gather them for us. I commend the Commission's 10 monographs and its final report, "Action for Mental Health", to you, to the Governors of our States, to members of the Congress and State legislatures, and to citizens across the land.

Can we take the Joint Commission's bold, carefully documented report and subject it to the process of public discussion and debate? Can we then take intelligent, constructive action? I think we can.

Today, mental illness, like heart disease or cancer, is a problem that concerns us all. We must move as a whole people-- through our democratically elected Federal, as well as State Governments, "to promote the general welfare" of each citizen.

At the legislative level Senator Lister Hill, who was the main sponsor of the legislation creating the Joint Commission, described its proposal for a

federal matching grant as "not only needed but warranted." Congressman John Fogarty, the acknowledged leader on all health matters in the House of Representatives, has also enthusiastically endorsed the recommendations of the Commission.

At the request of both the executive and legislative branches of the government, we have submitted draft legislation carrying out the Commission's major recommendations. Within a very short time, we hope to have a specific piece of legislation which can be thoroughly discussed at the state and local level.

Can we as a nation afford a tripling of mental health expenditures by 1970?

According to the American Psychiatric Association, the annual per capita expenditure for mental hospitals is only \$4.42 - figured on the hypothetical basis of each American contributing an equal sum for support of these services.

To triple this investment, the average American would have to give up one extra bottle of liquor and one chrome rod on his car.

It really gets down to a question of values; of how much we as a democracy want to spend for services designed to produce more effective and happier individuals.

We obviously place a great value upon highways, since we will spend \$41 billion in the next decade on them; this breaks down to a cost of one million dollars for every mile of this highway system.

We realize that the proposals of the Joint Commission will not be easy to legislate into effect, any more than it was easy to reform the hospital system of the Veterans Administration after World War II.

We could have gotten by with some patchwork solutions to the problem, but we decided that for once someone would tell the American people and their elected representatives the true costs of major reform. As we noted in the final report:

"Our proposal is the first one in American history that attempts to encompass the total problem of public support of mental health services and to make minimum standards of adequate care financially possible."

We are aware that many of our major recommendations need further discussion and technical study. They must be related to existing state programs and they must be carefully planned in relation to new federal and local efforts.

It is therefore our hope that you will authorize a special Governors' Conference, similar to the one in Detroit in 1954, at which the chief executives of the 50 states will sit down with their state mental health commissioners and local community mental health officials to plan ways in which the recommendations of the Joint Commission report can be applied at the grass roots level.

We who have been associated with the hammering out of this report over the last six years mean business.

I can also assure you that the 36 national organizations which have endorsed it, including the American Medical Association, the American Psychiatric Association, and the American Legion, mean business.

We are confident that the National Governors' Conference, which has done so much to improve care of the mentally ill in the several states over the past decade, will seize this golden opportunity to spearhead a major revolution in the handling of mental illness in this country.